APSEA | Serving Children and Youth Who are Deaf, Hard of Hearing/Blind or Visually Impaired

REFERRAL FOR SERVICE

Child Information:				
Name of Child: *First, Middle, Last*		**D.O.B.:** YY-MM-DD		**Male** ☐ **Female** ☐
Preferred Name:		**Home Language:**		
A Child who is Deaf or Hard of Hearing: ☐ **A Child who is Blind or Visually Impaired:** ☐				
Names of Parent(s)/Guardian(s):				
Full Address: *(including Street, Town)*		**Postal Code:**		
Telephone (Home):		**Work:**		
Cell:		**E-mail:**		

Please Note: ***A copy of the most recent Audiology Report or Eye Report must accompany this signed Referral for Services form.***

Mail or fax the completed form to: APSEA, 5940 South Street, Halifax, NS B3H 1S6
Attention: Director
Fax #: 902-423-8700

Additional Information:	
Reason for Referral:	
Additional Disabilities:	

FOR APSEA USE ONLY:			
Director, BVI/DHH:		**Date:**	

School & School District Information: **(To be completed for school aged referrals)**					
Name of School:					
Address:					
Telephone:		**Fax:**		**E-mail:**	
Principal:					
School Board/District:					
Student Services Coordinator:				**E-mail:**	
Student's Grade:					

Signatures:			
School/Preschool:		**Date:**	
Referring Agency:		**Date**	

I hereby grant permission for APSEA staff to complete observations and/or assessments to determine eligibility of my child for APSEA services.			
Parent/Guardian:		**Date:**	